TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HAYS SURGERY CENTER

Respondent Name
DEEP EAST TEXAS SELF INSURANCE

MFDR Tracking Number
M4-18-0120-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
SEPTEMBER 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are sending this to the medical fee dispute resolution because Tristar Risk Management is denying for timely filing. Originally, we were told the incorrect claim address and sent a claim to PO BOX 5228, Janesville, WI 53547. We were told that we billed to the wrong address. The correct address should be po box 2805 clinton, ia 52733 or fax to 562 506 0360. We faxed the claim and told them we had our notes history, which is provided, saying that this was generated on 02/14/2017. They did not take this and I told them that there is nothing else that shows our proof because we did not send certified mail."

Amount in Dispute: $7,302.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In regards to date of service 02/03/17 it was found the bill was received by the carrier's third party administrator Tristar Risk Management on 8/3/17 which was past the timely filing rule of 95 days. Although the requestor has submitted a fax confirmation showing it was sent on 6/6/17 there is no record it was received by the TPA and additionally the fax date would have also been past the 95 day time frame. Finally the screen print submitted as proof of timely filing does not meet the requirements set forth in the rule. The requestor has provided no valid proof of submission per Sec. 408.0272…In addition no reconsideration has been received for date of service at this time and does not qualify for medical dispute resolution."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2017	CPT Code 29888-LT	$3990.25	$0.00
	HCPCS Code C1762	$1980.00	$0.00
	HCPCS Code C1762	$273.90	$0.00
	HCPCS Code C1713	$497.20	$0.00

February 3, 2017	HCPCS Code C1713	$438.90	$0.00
	HCPCS Code C1713	$122.10	$0.00
	HCPCS Code A4649	$0.00	$0.00
	HCPCS Code A4649	$0.00	$0.00
TOTAL		$7,302.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.
4. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.

Issues

1. Did the requestor support position that the disputed bills were submitted timely?
2. Did the requestor support position that the disputed bills meets exception for timely filing?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing has expired."

   Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation finds fax confirmation reports dated June 6, 2017 and August 3, 2017. The division finds that based on these reports the bill was not submitted timely to the respondent.

2. The requestor contends that reimbursement is due because "Originally, we were told the incorrect claim address and sent a claim to PO BOX 5228, Janesville, WI 53547. We were told that we billed to the wrong address. The correct address should be po box 2805 clinton, ia 52733 or fax to 562 506 0360."

   Texas Labor Code §408.0272(b)(1) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely

claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title."

The requestor did not submit documentation to support that the claim was originally sent to "an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured," "a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee," or "a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title." The division finds the requestor did not support position that the disputed services qualify for the exception found in Texas Labor Code §408.0272(b)(1). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/6/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.